STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual/complaint survey was conducted at this facility from May 16, 2018 to May 30, 2018. The facility census the first day of the survey was 114. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited	E 000		
F 000	INITIAL COMMENTS An unannounced annual/complaint survey was conducted at this facility from May 16, 2018 to May 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 114. The survey sample size was 49. Abbreviations / definitions in this report are as follows: AAROM - active assistive range of motion; ABHR gel - A composite of four specific medications formulated into a gel for topical application. It is made from: Ativan, Benadryl, Haldol & Reglan It's purpose is to treat agitation and anxiety; Abilify - antipsychotic medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; ADL - activities of daily living;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/26/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ADON - Assistant Director of Nursing;
Alendronate - medication that slows calcium loss from bones;
Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying or Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth;
APAP- Tylenol;
Bacitracin- antibiotic ointment;
BMP - Basic Metabolic Panel/set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance;
BIMS-Brief Interview for Mental Status;
Buspar- medication used to treat anxiety;
CAT Scan - imaging test that takes detailed pictures of the inside of the body;
CBC - Complete Blood Count/blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia;
CDC - Centers for Disease Control and Prevention;
Cervical fusion- surgery that permanently connects two or more vertebrae in the neck to relieve severe neck pain and other symptoms such as arm numbness;
Cervical hardware- rods, screws, hooks, wires, and plates, for example;
CNA - Certified Nurses Aide;
Cognitive-thinking, memory;
Contracture - joint limitations with fixed high resistance to passive stretch of a muscle;
COPD (Chronic Obstructive Pulmonary Disease) - pulmonary disease that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation;
Constipation - difficulty in passing stool;
Corporal punishment- physical punishment

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intended to cause pain;
DON - Director of Nursing;
DM (Diabetes Mellitus)- disease where sugar levels are too high;
DX (dx) - diagnosis;
eMAR - electronic Medication Administration Record;
Epigastric - upper central area of the abdomen;
ER - Emergency Room;
Flexion - the action of bending or the condition of being bent, especially the bending of a limb or joint;
GERD - gastroesophageal reflux disease/occurs when stomach acid or, occasionally, stomach content, flows back into your food pipe;
Gerichair - wheelchair type-chair that reclines;
Hemorrhoid - enlarged blood vessels at the anus;
HS (hs) - at bedtime;
Keflex - an antibiotic used to treat certain kinds of bacterial infections;
L - liter;
Lisinopril-medication for high blood pressure;
LPN - Licensed Practical Nurse;
Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause;
MAR - medication administration record
MDS - Minimum Data Set (standardized assessment forms used in nursing homes);
mg - milligrams/a unit of mass;
MRR - Medication Regimen Review/monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist;
Matrix - healthcare software computer program;

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Miralax- laxative used to treat constipation;
Nasal cannula- tube placed into nostrils to deliver oxygen;
NHA- Nursing Home Administrator;
Neurological assessment - series of simple questions and physical tests to determine if the nervous system is impaired;
Omeprazole - medication used to reduce stomach acid;
OT - Occupational Therapy;
OxyIR - Oxycodone Immediate Release/medication used to treat pain;
ROM - range of motion;
Parameters - clinical measurement;
POS - physician order sheet;
Prandin- medication used to treat diabetes mellitus;
Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
PRN - as needed;
PROM - passive range of motion;
Psychiatric - relating to mental illness or its treatment;
Psychotropic - any medication capable of affecting the mind, emotions and behavior;
Pulse Oximetry - measures blood oxygen saturation levels - desired range 94% to 100%;
Q - every;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
ROM-range of motion;
Saline- a solution of salt in water;
Senile degeneration of the brain- the decline and death of nervous system cells called neurons. It is progressive, meaning that the condition worsens over time as greater numbers of neurons in the brain die. As the brain gradually deteriorates, the

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F 000	Continued From page 4 patient loses intellectual function in key areas such as speech, memory and spatial skills; Statin - cholesterol lowering drug Systolic Blood Pressure (SBP) - the top number of the blood pressure reflects pressure in vessels when the heart is beating; TID - three times a day; Titrate - continuously measure and adjust the balance of; Triamcinolone - used to treat psoriasis (chronic skin disease with plaque formation); Vistaril- medication used to treat nausea and vomiting, anxiety, severe itching, and to induce sedation before or after anesthesia. It is also used off- label to treat insomnia and symptoms of opioid withdrawal; %-percent.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		9/1/18

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F 550	Continued From page 5 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that staff addressed all the residents with respect when referring to residents eating in the dining room. Findings include: During breakfast observation in the second floor dining room on 5/29/18 at 8:00 AM, an interview was conducted with E9 (Dietary Aide) regarding seating arrangements and meal service in the dining room when residents came in for breakfast. E9 stated there were no specific areas designated for "feeders" and "walkers." E9 repeated the statement using the labels when asked to confirm her response. The dining room was quiet and had two residents seated at a table	F 550	1. No resident was negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff Developer educated existing staff on resident's rights, dignity, and respect. Agenda for New Hire Orientation (NHO) amended to include education on resident's rights, dignity, and respect. Also Annual Mandatory Requirements (AMR) education, which is conducted annually at each employee's anniversary date of employment, updated to include	

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F 550	Continued From page 6 no more than six feet from where this interview took place. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/30/18 at 6:00 PM.	F 550	the same. 4. Staff educator to perform random staff observations to ensure that residents are addressed with dignity and respect. Three random staff member observations will be done daily or until 100% compliance is achieved for three consecutive days. Observations will then be done three times weekly or until 100% compliance is reached for three consecutive times. Observations will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three staff observations are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QAPI monthly.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		9/1/18

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F 583	Continued From page 7 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure privacy during treatment for one (R40) out of 49 sampled residents. Findings include: On 5/16/18 at 8:52 AM, R40 was observed sitting in a chair in her room with her door open in slacks and bra, getting her blood pressure taken by E10 (RN). R40 was in plain sight from the hallway. During this time a male resident (R42) went down the hallway and stopped to look into R40's room. E10 finished the blood pressure reading and exited R40's room without closing the door. When questioned as to why she did not close the door, E10 stated she was going back in to give her medication. E10 went back into the room and closed the door. The facility failed to ensure R40 was removed	F 583	1. R40 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff Developer educated existing staff on resident rights, dignity, and respect. Agenda for New Hire Orientation (NHO) amended to include education on resident's rights, dignity, and respect. Also Annual Mandatory Requirements (AMR) education, which are conducted annually on each employee's anniversary of employment, updated to include the same. 4. Staff educator to perform random resident dignity and respect observations to ensure that residents are addressed	

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F 583	Continued From page 8 from public view during the delivery of care when she was not fully dressed. Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Exec. Nurse) on 5/30/18 at approximately 3:30 PM.	F 583	with dignity and respect. Three random resident observations will be done daily or until 100% compliance is achieved for three consecutive days. Observations will then be done three times weekly or until 100% compliance is reached for three consecutive times. Resident observations will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved. Results of resident observations will be presented at QAPI monthly.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		9/1/18

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F 584	Continued From page 9 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that for 3 (Room 101, Room 166 and Room 275) out of 27 rooms, the facility failed to ensure that all furniture and room interior were maintained in good repair. Findings include: During the environment inspection with E8 (Maintenance Director) on 5/24/18 from 9:04 AM to 10:00 AM, the following observations were made, and confirmed with E8 on 5/24/18 at 9:10 AM: Room 101: - The left armrest for a geri-chair had frayed edges revealing the material inside; - A closet door had a hole on its lower left side. Room 166:	F 584	1. No resident was negatively impacted by this deficient practice. Walls and wall paper were immediately repaired upon discovery. Frayed arm rest was replaced. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Maintenance Director/Designee to perform routine room and equipment assessments to ensure that everything is in good repair. Each room will be fully inspected no less than one time per month. 4. Maintenance Director/Designee will conduct three random room inspections per day to ensure compliance daily until	

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F 584	Continued From page 10 - The wallpaper to the left of the bed was peeling off the wall. Room 275: - There were 3 holes in the wall in-between 2 closets and 2 holes in the wall by the hallway. Findings were reviewed with E1 and E2 on 5/30/18 at 6:00 PM.	F 584	100% compliance is reached over three consecutive days. Maintenance Director/Designee will conduct three random room inspections three times weekly until 100% compliance is met for three consecutive audits. Maintenance Director/Designee will conduct three random room inspections weekly until 100% compliance is met over three consecutive weeks. Maintenance Director/Designee will conduct three random room inspections in one month, if 100% compliance, the deficiency will be considered resolved. Each resident room will be fully inspected for repair needs no less than once a month on an ongoing basis. Results of audits to be presented and discussed at QAPI monthly.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		9/1/18

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F 600	Continued From page 11 Based on record review, interview and review of facility documentation, it was determined that for 2 (R15 and R46) out of 49 sampled residents, the facility failed to ensure that both residents were free from physical abuse from resident to resident altercations. Findings include: The facility policy titled, "Abuse, Neglect, Mistreatment, Misappropriation and Exploitation," last revised 12/12/16, stated, "...all patients and residents will be free from abuse, neglect, mistreatment, misappropriation of resident property and exploitation ...DEFINITIONS: (1) "Abuse" shall mean:...A. Physical abuse by unnecessarily inflicting pain or injury to a patient or resident. This includes but is not limited to, hitting, kicking, punching, slapping, pulling hair, or corporal punishment of any kind..." Cross refer F609 1. Review of R15's clinical record revealed: R15 was admitted to the facility on 5/24/17. An admission MDS was completed on 5/31/17 and revealed that R15 was cognitively intact. An incident report from an event on 2/26/18 at 3:32 PM, stated that R20 wheeled her wheelchair into R15's room, came up behind R15 and hit him in the head and then grabbed the back collar of his shirt at the neck area and pulled it with both hands. R15 yelled for the nurse to help remove R20 from him. The nurse came in the room and found R20 pulling on R15's shirt and choking him from behind. The nurse removed R20 from R15's room. R15 was noted to have a reddened neck. An incident report from an event on 4/22/18 at	F 600	#1 1. R15 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected and may result in abuse towards another resident, will be sent to the hospital for evaluation and treatment. 4. Unit Manager/Designee to perform random resident observations on residents with a history of aggressive behaviors. Three random resident observations will be done daily or until 100% compliance is achieved for three consecutive days. Observations will then be done three times weekly or until 100% compliance is reached for three consecutive times. Observations will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of observations are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QA Committee Meeting. #2 1. R46 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse.	

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F 600	Continued From page 12 4:00 PM, stated that R15 was on the computer at the back of the hallway when R42 hit him on the back of his neck. The residents were separated and redirected to safety. Review of a physician progress note from 4/23/18 at 2:20 PM stated, R15 was concerned due to his history of a cervical fusion that his cervical hardware may have shifted. A nursing progress note, dated 4/23/18 and timed 9:18 PM, stated that R15 was being monitored for pain in the back of his neck and R15 stated that he was still a little sore. A progress note from 4/24/18 at 12:05 PM, stated that R15 received an x-ray of his spine that showed his cervical hardware was intact. A nurse practitioner progress note from 4/25/18 at 12:04 PM stated, R15 had complained of pain in the neck at the time of the incident on 4/22/18. During an interview on 5/16/18 at 11:45 AM, R15 stated that he had been "attacked" by two different residents within the past few months. He stated that R20 hit him in his head and choked him around his neck with his shirt. R15 also stated that R42 "beat him" behind his neck like a "sledge hammer." [incident report 2/6/18 at 11:57 AM]R20 expressed that these events were very upsetting to him and staff were aware. R15 stated that he was concerned because he had a cervical spinal fusion in the past and was afraid these incidents may have caused damage. He further stated that he had an x-ray after the most recent incident (4/22/18) and he was told there were no issues. The facility failed to ensure that R15 was free	F 600	2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected and may result in abuse towards another resident, will be sent to the hospital for evaluation and treatment. 4. Unit Manager/Designee to perform random resident observations on residents with a history of aggressive behaviors. Three random resident observations will be done daily or until 100% compliance is achieved for three consecutive days. Observations will then be done three times weekly or until 100% compliance is reached for three consecutive times. Observations will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of observations are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QA Committee Meeting.	

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	085056	A. BUILDING _____ B. WING _____	C 05/30/2018

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F 600	Continued From page 13	F 600		

from physical abuse on 2/26/18, when R20 hit him in the head and choked him from behind causing his neck to become reddened, and on 4/22/18, when R42 hit him in the back of the neck causing pain and the need for an x-ray to be completed to rule out damage.
Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.

2. Review of R46's clinical record revealed:

R46 was admitted to the facility on 12/20/17.

The most recent quarterly MDS on 4/6/18 revealed that R46 was cognitively intact.

An incident report from an event on 1/18/18 at 5:00 PM, stated that R20 wheeled in front of the first floor nurses station and approached R46. R20 then grabbed R46 by the left arm and threatened to hit her. The two residents were separated and redirected. R46 sustained a scratch to her left forearm near the elbow. The area was cleansed with saline and a small amount of antibiotic was applied.

On 1/19/18 at 10:45 AM, the incident report was updated and included that R46 now had bruising to her left arm.

On 1/19/18 at 12:14 PM, the facility self-reported an injury for R46 to the State Agency. The incident report stated that R20 grabbed R46's arm in front of the nurse's station and there was no injury noted upon initial assessment. R46 was assessed that morning (1/19/18) and was noted to have bruising to left arm where R20 grabbed her.

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F 600	Continued From page 14 The facility failed to ensure that R46 was free from physical abuse on 1/19/18, when R20 grabbed R46's left arm and caused R46 to obtain a scratch and bruise where she was grabbed. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		9/1/18

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F 609	Continued From page 15 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the State of Delaware Division of Healthcare Quality (DHCQ) Incident Reporting Program, it was determined that for five (R15, R20, R22, R42, and R50) out of 49 sampled residents, the facility failed to notify the state agency within 2 hours of potential abuse from multiple resident to resident altercations. Findings include: Cross refer F600 1. Review of R15's clinical record revealed: a. An incident report from an event on 2/26/18 at 3:32 PM, stated that R20 wheeled her wheelchair into R15's room, then came up behind R15 and hit him in the head and then grabbed the back collar of his shirt at the neck area and pulled it with both hands. R15 yelled for the nurse to help remove R20 from him. The nurse came in the room and found R20 pulling on R15's shirt and choking him from behind. The nurse removed R20 from R15's room. R15 was noted with a reddened neck, but had no complaints of pain or difficulty swallowing. On 5/30/18, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the altercation between R15 and R20 was reported to the state agency. b. An incident report from an event on 4/22/18 at 4:00 PM, stated that R15 was on the computer at the back of the hallway when R42 hit him on the back of his neck. The residents were separated	F 609	#1 1A. R15 did not sustain any major injuries as a result of this resident to resident abuse. 1B. R15 did not sustain any major injuries as a result of this resident to resident abuse. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Regulatory changes regarding reporting of alleged effective November 2017 reviewed with all management and supervisors, reference sheet created and provided to all management and supervisors to assist with compliance. 4. Investigation Team (DON, ADON, and NHA)to meet daily on all allegations of abuse for three consecutive days to ensure compliance of reporting regulations or until 100% compliance is achieved. Investigation team will meet three times weekly or until 100% compliance is reached for three consecutive times. Investigation team will meet one time a week for three consecutive weeks or until 100% compliant. If investigations are 100% compliant in one month the deficiency will be considered resolved. Results of investigations will be presented at QA Committee Meeting.	

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F 609	Continued From page 16 and redirected to safety. On 5/30/18, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the altercation between R15 and R42 was reported to the state agency. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM. 2. Review of R22's clinical record revealed: An incident report from the event on 3/7/18 at 6:00 PM, stated that R20 was seated next to R22 when she grabbed R22's right arm and began hitting her. The nurse separated the residents from each other. On 5/30/18, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the altercation between R20 and R22 was reported to the state agency. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM. 3. Review of R42's clinical record revealed: An incident report from an event on 2/6/18 at 11:57 AM, stated that R42 was taunting R20 by the entrance to the dining room. R42 rolled by R20 in his wheelchair and R20 became aggressive and hit R42 three times in the upper right shoulder and grabbed at his shirt. Nursing staff separated R20 and R42. On 5/30/18, review of the State of Delaware	F 609	#2 1A. R22 did not sustain any major injuries as a result of this resident to resident abuse. 1B. R22 did not sustain any major injuries as a result of this resident to resident abuse. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Regulatory changes regarding reporting of alleged effective November 2017 reviewed with all management and supervisors, reference sheet created and provided to all management and supervisors to assist with compliance. 4. Investigation Team (DON, ADON, and NHA)to meet daily on all allegations of abuse for three consecutive days to ensure compliance of reporting regulations or until 100% compliance is achieved. Investigation team will meet three times weekly or until 100% compliance is reached for three consecutive times. Investigation team will meet one time a week for three consecutive weeks or until 100% compliant. If investigations are 100% compliant in one month the deficiency will be considered resolved. Results of investigations will be presented at QA Committee Meeting. #3 1A. R42 did not sustain any major injuries as a result of this resident to resident abuse.	

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F 609	Continued From page 17 DHCQ Incident Reporting Program revealed no evidence that the altercation between R20 and R42 was reported to the state agency. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM. 4. Review of R50's clinical record revealed: An incident report from an event on 2/18/18 at 2:05 PM, stated that R20 approached R50 in the lounge and told R50 "you're gonna get it." R20 then hit R50 across the chest and staff separated the two residents from each other. On 5/30/18, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the altercation between R20 and R50 was reported to the state agency. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 609	1B. R42 did not sustain any major injuries as a result of this resident to resident abuse. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Regulatory changes regarding reporting of alleged effective November 2017 reviewed with all management and supervisors, reference sheet created and provided to all management and supervisors to assist with compliance. 4. Investigation Team (DON, ADON, and NHA)to meet daily on all allegations of abuse for three consecutive days to ensure compliance of reporting regulations or until 100% compliance is achieved. Investigation team will meet three times weekly or until 100% compliance is reached for three consecutive times. Investigation team will meet one time a week for three consecutive weeks or until 100% compliant. If investigations are 100% compliant in one month the deficiency will be considered resolved. Results of investigations will be presented at QA Committee Meeting. #4 1A. R50 did not sustain any major injuries as a result of this resident to resident abuse. 1B. R50 did not sustain any major injuries as a result of this resident to resident abuse. 2. All residents have the potential to be	

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F 609	Continued From page 18	F 609	impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Regulatory changes regarding reporting of alleged effective November 2017 reviewed with all management and supervisors, reference sheet created and provided to all management and supervisors to assist with compliance. 4. Investigation Team (DON, ADON, and NHA)to meet daily on all allegations of abuse for three consecutive days to ensure compliance of reporting regulations or until 100% compliance is achieved. Investigation team will meet three times weekly or until 100% compliance is reached for three consecutive times. Investigation team will meet one time a week for three consecutive weeks or until 100% compliant. If investigations are 100% compliant in one month the deficiency will be considered resolved. Results of investigations will be presented at QA Committee Meeting.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		9/1/18

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assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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F 636	Continued From page 20 prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R26) out of 49 sampled residents, the facility failed to assess R26's activity preferences on the admission resident assessment instrument. Findings include: Review of R26's admission MDS from 12/15/17 revealed she had a Brief Interview for Mental Status (BIMS) conducted, and had a score of 13 (able to independently make decisions regarding daily life). R26's functional status revealed she needed one person extensive assistance for transfer into the wheelchair. Review of the Preferences for Customary Routine Activities revealed this section had not been completed. All 20 questions in this section were marked 'Not assessed/no information'. On 5/16/18 during an interview at 2:03 PM with R26, she stated she has a partial left foot amputation and needs help with transfers. R26 stated she would like to go to seated exercise, but had not been asked if she would like to attend any activities. On 5/22/18 during an interview with E11 (Activity	F 636	1. R26 resident was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. All current residents will be audited that their preferences are in place and accurate. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Activity Director/Designee to attend all 48 hour Care Conferences to ensure preferences are captured timely and to initiate a comprehensive assessment to promote resident centered care. 4. RNAC to ensure Activity preferences are completed daily on Admission/Readmission with Significant Change assessments or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random audit of activity preferences are 100% compliant in one month the	

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F 636	Continued From page 21 Director), at 9:25 AM, E11 stated that the lack of activity preferences should have been picked up during R26's care conference in March 2018. On 5/22/18 during an interview with E12 (MDS Coordinator), at 9:46 AM, E12 confirmed that the activity preferences on the admission MDS for R26 had not been completed. The facility failed to conduct a comprehensive assessment of R26's activity preferences. Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Exec. Nurse) on 5/30/18 at approximately 3:30 PM.	F 636	deficiency will be considered resolved. Results of audits will be presented at QAPI monthly.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		9/1/18

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F 656	Continued From page 22 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R26) out of 49 sampled residents, the facility failed to develop and implement a person centered care plan consistent with R26's preferences for activities. Findings include: Cross refer to F636. R26's 12/15/17 admission MDS revealed, she had a Brief Interview for Mental Status (BIMS) conducted with a score of 13 (able to independently make decisions regarding daily life). R26's functional status revealed she needed one person extensive assistance for transfer into the wheelchair. Review of the Preferences for Customary Routine Activities	F 656	1. R26 resident was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Activity Director/Designee to review/amend activity preferences during Quarterly Care Conferences to ensure resident centered care is maintained consistently. All current residents will be reviewed that their preferences are in place and accurate. 4. RNAC to ensure Activity preferences are completed daily on Admission/Readmission with Significant	

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F 656	Continued From page 23 revealed this section had not been completed. All 20 questions in this section were marked 'Not assessed/no information'. Review of R26's care plan, last edited on 3/19/18 by E12 (MDS Coordinator), included 'invite resident to attend bus trip outings, offer resident Catholic communion and invite to Mass, escort to group activities of choice'. On 5/16/18 during an interview at 2:03 PM, R26 stated she had a partial left foot amputation and needed help with transfers. R26 stated she received a daily activity calendar and she would like to go to the seated exercise activity, but had not been asked by staff if she would like to attend any activities. On 5/22/18 during an interview at 9:25 AM, E11 (Activity Director) stated that the lack of activity preferences should have been picked up during R26's care conference in March 2018. On 5/22/18 during an interview at 9:46 AM, E12 (MDS Coordinator) confirmed that the activity preferences on the admission MDS for R26 had not been completed. The facility failed to conduct a comprehensive assessment of R26's activity preferences. Findings were reviewed with E1 (NHA) and E2 (DON), and E4 (Corporate Exec. Nurse) on 5/30/18 at approximately 3:30 PM.	F 656	Change assessments or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random audit of activity preferences are 100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QAPI monthly.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		9/1/18

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F 658	Continued From page 24 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation, it was determined that for one (R84) out of 49 sampled residents, the facility failed to meet professional standards of quality. The facility failed to perform a complete neurological assessment immediately after R84's 4/6/18 unwitnessed fall; and lacked evidence that R84's physician-ordered neurological assessments were completed as ordered. Findings include: The facility's Fall Prevention Resident Assessment and Management policy, last revised on 12/19/16, stated, "...Unwitnessed Fall...The nurse obtains physician orders for Neuro Checks...". Review of R84's clinical record revealed the following: 4/2/18 - R84 was admitted to the facility for short-term rehabilitation with a history of falls. 4/6/18 - The facility's Fall Report stated that R84 fell while attempting to transfer from her bed to her wheelchair without staff assistance at 4:16 AM. Further review of R84's Fall Report lacked evidence of a complete neurological assessment immediately after her unwitnessed fall. 4/6/18 - A Physician's Order stated to perform post fall neurological checks every 30 minutes x 2 times, then every 1 hour x 4 times, then every	F 658	1. R84 was not negatively impacted by this deficient practice. 2. All residents who fall have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff Educator to educate all nurses on facility's Fall Prevention Resident Assessment and Management policy that all resident neurologic assessments are completed. Corporate Informatics nurse to modify nurse electronic documentation and place "hard stop" on neurological assessment to ensure completion of assessment by staff nurse. 4. ADON/designee during Fall Committee meeting will audit compliance daily or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random audit of neurologic assessments are 100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QA Committee Meeting.	

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F 658	Continued From page 25 shift x 9 times. 4/6/18 to 4/10/18 - Review of R84's clinical record lacked evidence that her physician-ordered neurological checks were performed as ordered. 5/29/18 at 4 PM - During an interview, findings were reviewed with E2 (DON). The facility failed to perform a complete neurological assessment immediately after R84's 4/6/18 unwitnessed fall; and lacked evidence that R84's physician-ordered neurological assessments were completed as ordered. 5/30/18 at 6 PM - Findings were reviewed with E1 (NHA) and E2 during the Exit Conference.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following	F 676		9/1/18

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F 676	Continued From page 26 activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to provide assistance with meals for 1 (R5) out of 49 sampled residents. Findings include: During breakfast observation on 5/28/18 between 8:35 AM and 9:05 AM, R5 was observed asleep in bed in an upright position, with her breakfast tray in front of her. R5 was alone in the room. Observation of R5 at 8:45 AM and again at 9:00 AM found the resident in the same position with the breakfast tray untouched. At 9:05 AM, R5 remained in the same position, but without the breakfast tray in front of her. Review of R5's MDS Quarterly Review of 2/20/18 revealed R5 was a hospice resident who required supervision by one person to provide oversight, encouragement or cueing during meals.	F 676	1. R5 was not negatively impacted by this deficient practice. 2. All residents have the who require assistance with feeding have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Facility will create and maintain a list of all residents that require feeding assistance. List to be maintained inside the C.N.A. assignment binder to ensure all staff are aware of which residents require feeding assistance. 4. Dietician to perform three random resident observations of residents who require feeding assistance during meal time daily until 100% compliance is achieved for three consecutive days. Audits will then be done three times	

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F 676	Continued From page 27 In an interview on 5/30/18 at 1:20 PM, E7 (Registered Dietitian) confirmed that R5 needed cueing at mealtimes to encourage intake. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/30/18 at 6:00 PM.	F 676	weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three audits are 100% compliant in one month the deficiency will be considered resolved. Results of observations will be presented at QAPI monthly.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for 1 (R84) out of 49 sampled residents, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. For R84, the facility failed to address her 4/6/18 complaint of hemorrhoid pain until four (4) days later on 4/9/18. Findings include: Review of R84's clinical record revealed the following: 4/2/18 - R84 was admitted to the facility for	F 684	1. R84 was not negatively impacted by this deficient practice. R84 was medicated for pain as indicated upon request. 2. All residents with hemorrhoids have the potential to be impacted by this deficient practice. Future residents with hemorrhoids will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Facility will increase medication house stock to include hemorrhoid medication so that it is readily available upon request. Unit Manager/Designee to review Facility Activity Report daily to ensure all	9/1/18

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F 684	Continued From page 28 short-term rehabilitation. 4/6/18 at 7:46 AM - A Nurse's Note stated that R84 was complaining of hemorrhoid pain and the physician was made aware. 4/6/18 and untimed - Review of the nurse's handwritten entry in the Physician's Communication Record revealed that R84 complained of hemorrhoid pain. 4/9/18 at 11:39 AM - A Physician's Progress Note stated that R84 was seen, complained of hemorrhoids and was ordered medication. 4/9/18 at 8 PM - R84's eMAR revealed that she received the first application of the physician-ordered hemorrhoid medication, approximately 4 days after she complained of hemorrhoid pain. 5/29/18 at 4 PM - During an interview, findings were reviewed with E2 (DON). The facility failed to address R84's 4/6/18 complaint of hemorrhoid pain until four (4) days later on 4/9/18. 5/30/18 at 6 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 684	complaints of hemorrhoid pain are promptly addressed and that a standing physician order for hemorrhoid medication is in place. 4. Unit Manager/Designee to review Facility Activity Report daily to ensure all complaints of hemorrhoid pain are promptly addressed and that physician ordered hemorrhoid medication is in place daily or until 100% compliance is achieved for three consecutive days. Review will then be done three times weekly or until 100% compliance is reached for three consecutive times. Review will continue at one time a week for three consecutive weeks or until 100% compliant. If a random review of hemorrhoid complaints are 100% compliant in one month the deficiency will be considered resolved. Results of review audits will be presented at QA Committee Meeting.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		9/1/18

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F 688	Continued From page 29 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility documentation, it was determined that for one (R5) out of 49 sampled residents, the facility failed to ensure appropriate treatment and services to increase range of motion (ROM) and/or to prevent further decrease in range of motion were provided; and failed to ensure appropriate services, equipment and assistance to maintain mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable was also provided. Findings include: Review of R5's clinical record revealed the following: R5 was admitted to the facility on 2/25/15 with diagnoses that included senile degeneration of the brain, generalized muscle weakness, and difficulty in walking. Review of R5's care plan showed starting on 2/28/15, R5 needed assistance with ADL's secondary to many diagnoses including a frozen left shoulder. There was no care plan for R5's potential for contractures or decreased ROM.	F 688	1. R5 resident was not negatively impacted by this deficient practice. 2. All Hospice residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Social Services Director will report to the NHA any therapy evaluation request to Hospice companies to ensure timely completion of the therapy evaluation regardless of Hospice approval. Facility will provide therapy evaluation to prevent ROM decline regardless of whether Hospice approves therapy services or not. 4. Social Service Director/Designee to maintain a list of all Hospice residents and whether or not they are on therapy case load or require therapy services and audit daily or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive	

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F 688	Continued From page 30 Review of R5's therapy ROM assessments revealed the 11/4/16 and 1/24/17 assessments stated that R5 did not have any contractures. The 6/20/17 assessment stated that R5 did not have any contractures, but noted that R5 had increased tone and tightness in both shoulders and had decreased shoulder ROM. The assessment stated that R5 stated she did not want therapy services. The facility failed to develop a care plan for R5's decreased ROM after this assessment. A care conference note dated 8/31/17 revealed that R5's family asked staff about her ROM. The note stated that nursing would continue ROM for the resident and the social worker would see if hospice would approve a therapy evaluation and treatment. An order for a therapy evaluation and treatment was never placed after this conference and R5's clinical record lacked evidence that the facility discussed this any further with R5's family. The 11/3/17 therapy ROM assessment stated that R5 had a minimal contracture to her left shoulder and her left shoulder, left hip, and left knee were limited. There was no documentation of R5 or R5's representative being offered therapy services after this assessment. Review of R5's orders revealed that starting on 11/19/17, R5 was to receive PROM to her left sided joints and AAROM to her right sided joints twice daily for 15 minutes each session. Review of R5's care plan showed that on 11/19/17, R5 had a care plan added for the problem, actual contractures to left shoulder. Approaches included to monitor for and report	F 688	weeks or until 100% compliant. If a random sample of three audits are 100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QA Committee Meeting.	

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F 688	Continued From page 31 any changes in R5's ROM during daily care and to provide PROM to her left sided joints and AAROM to her right sided joints twice daily for 15 minutes each session. The goal, last edited on 2/23/18, stated that R5 will have no new contractures per visual assessment or increase in current contractures per therapy measurement x 90 days. The 5/22/18 therapy ROM assessment showed a decline and stated that R5 now had a minimal contracture to her left shoulder, left hip, left knee, and right knee. The assessment stated that R5 had decreased flexion to both shoulders, knees, and left hip due to resistance. The therapist also noted that R5 had increased resistance to PROM on this date. During an interview on 5/24/18 at 3:50 PM, E21 (Director of Social Services) provided documentation that showed E21 emailed R5's hospice social worker on 8/31/17 asking if R5 could have an OT Evaluation and Treatment. The hospice social worker stated she would discuss it with the hospice team. E21 emailed the hospice social worker again on 9/6/17 to follow up and was told the RN case manager was checking with the hospice doctor and if he approved it the facility doctor could order the OT evaluation. E21 stated that after this email hospice never confirmed if R5 could or could not get an OT evaluation and the facility did not follow up again. The facility failed to provide services to prevent R5's reduction in ROM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 688		

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview, and review of facility documentation, it was determined that for one (R20) out of 49 sampled residents, the facility failed to ensure that R20 received adequate supervision to prevent multiple resident to resident [R46, R42, R50, R15, R22] altercations. Findings include: Review of R20's clinical record revealed: R20 was admitted to the facility on 6/1/17 with diagnoses including severe major depressive disorder with psychotic symptoms, senile degeneration of the brain, and an anxiety disorder. The facility developed a care plan on 6/20/17 for the problem that R20 displayed verbally abusive behaviors as evidenced by yelling, cursing, screaming, and derogatory statements towards staff and other residents. a) An incident report from an event on 1/18/18 at 5:00 PM, stated that R20 was in her wheelchair in front of the first floor nursing station when she approached R46 and grabbed her arm and threatened to hit her. R46 sustained a scratch to	F 689	1A. R46 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse. 1B. R42 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse. 1C. R50 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse. 1D. R15 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse. 1E. R22 was not negatively impacted by this deficient practice. Resident did not sustain any major injuries as a result of this resident to resident abuse. 2A. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 2B. All residents have the potential to be impacted by this deficient practice. Future	9/1/18

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F 689	Continued From page 33 her left forearm near the elbow and her left arm was bruised the following morning. The facility stated that the event most likely occurred from anxiety from R20 having a disruption in her daily routine due to her husband not being available recently for visits. The facility stated they would continue with the plan of care and monitor for behaviors and psychotropic medication side effects, and ensure R20 was invited to attend all facility activities and engaged in 1:1 if needed for redirection. In addition to R20 was receiving ABHR gel (for anxiety) as needed, a routine order was added for ABHR gel to be given twice daily every 12 hours. R20's supervision was not increased after this incident. b) An incident report from an event on 2/6/18 at 11:57 AM, stated that R42 was taunting R20 by the entrance to the dining room. R42 rolled by R20 in his wheelchair and R20 became aggressive and hit R42 three times in the upper right shoulder and grabbed at his shirt. Nursing staff separated R20 and R42. No injuries were found after the incident. Supervision was not increased after this incident. R20 was seen by psychiatry after this incident and R20's ABHR gel routine order was changed to be given every 6 hours on 2/7/18 then it was decreased to three times a day on 2/9/18. c) An incident report from an event on 2/18/18 at 2:05 PM, stated that R20 approached R50 in the lounge and told R50, "you're gonna get it." R20 then hit R50 across the chest and staff separated the two residents from each other. No injuries were found after the incident. The facility determined they would continue to monitor R20 for behaviors, redirect as needed, and ensure R20 was invited to attend all facility activities and	F 689	residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 2C. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 2D. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 2E. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3A. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected and may result in abuse towards another resident, will be placed on 1:1 observation until transportation to hospital arrives (refer to F609)or behavior subsides. 1:1 supervision will be documented on daily staffing deployment sheet. 3B. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected and may result in abuse towards another resident, will be placed on 1:1 observation until transportation to hospital arrives (refer to F609)or behavior subsides. 1:1 supervision will be documented on daily staffing deployment sheet. 3C. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected	

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F 689	Continued From page 34 engaged in 1:1 if needed for redirection. Supervision was not increased after this incident. d) An incident report from an event on 2/26/18 at 3:32 PM, stated the R20 wheeled her wheelchair into R15's room. R20 then wheeled up behind R15 and hit him in the head and then grabbed the back collar of his shirt at the neck area and pulled it with both hands. R15 yelled for the nurse to help remove R20 from him. The nurse came in the room and found R20 pulling on R15's shirt and choking him from behind. The nurse removed R20 from R15's room. R15 was noted with a reddened neck, but no complaints of pain or difficulty swallowing. Supervision was not documented to be increased after this incident. Following this incident, a progress note on 2/27/18 at 9:44 AM, stated that E21 (Director of Social Services) called R20's daughter to discuss increasing behaviors and future placement for R20 in another facility for safety of the resident and other residents. The daughter was agreeable and a referral was made. The facility developed a care plan on 2/27/18 for the problem that R20 was a potential safety hazard to self and others as evidenced by wandering in and out of other's rooms. Approaches included psychiatric consults as needed, re-directing R20 back to the floor or her room, and provide distractions such as activities or talking with the resident. Approaches did not include increased supervision. A progress note from 3/2/18 at 6:28 PM, stated that R20 was trying to hit other residents and staff. The ABHR gel for agitation was given and was noted to not be very effective. R20 was noted to be trying to get into other residents rooms and	F 689	and may result in abuse towards another resident, will be placed on 1:1 observation until transportation to hospital arrives (refer to F609)or behavior subsides. 1:1 supervision will be documented on daily staffing deployment sheet. 3D. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected and may result in abuse towards another resident, will be placed on 1:1 observation until transportation to hospital arrives (refer to F609)or behavior subsides. 1:1 supervision will be documented on daily staffing deployment sheet. 3E. For any resident demonstrating physically aggressive behaviors towards other residents that can not be redirected and may result in abuse towards another resident, will be placed on 1:1 observation until transportation to hospital arrives (refer to F609)or behavior subsides. 1:1 supervision will be documented on daily staffing deployment sheet. Sample demployment sheet submitted directly to Division of Long Term Care Residents' Protection. 4A-E. Investigation Team (DON, ADON, NHA) to audit daily staffing deployment sheets for 1:1 staffing that 1:1 supervision was appropriately provided and documented for aggressive residents until 100% compliance for three consecutive days is achieved. Investigation team will review daily staffing deployment sheet weekly or until 100% compliance is reached for three consecutive times. Investigation team audit daily staffing deployment sheets one time a week for	

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F 689	Continued From page 35 hit them. The nurse stated that a psychiatric evaluation would be placed and R20's daughter was called. On 3/2/18 at 7:02 PM an order for R20 to have safety checks every 30 minutes was ordered. A progress note on 3/6/18 at 10:27 AM by E21, stated that the referral for R20 was declined and the other facility would not accept R20. e) After initiating safety checks every 30 minutes, R20 had another resident to resident incident on 3/7/18. An incident report from the event on 3/7/18 at 6:00 PM, stated that R20 was seated next to R22 when she grabbed R22's right arm and began hitting her. The nurse separated the residents from each other. R20 was taken to a quiet area and staff were unable to calm her down. R20 continued to be verbally and physically aggressive towards staff and stated to the nurse that she wanted to grab her and kill her. The physician was notified and ordered to send R20 to the hospital emergency room for evaluation, including a psychiatric evaluation. At the hospital, R20 received a CAT scan of the abdomen and pelvis, lab work, urinalysis, and urine culture and sensitivity. The urine was slightly contaminated, but R20 received an order to receive Keflex (antibiotic) 500 mg every 12 hours for 10 days. She continued to have agitation at the hospital, but was transferred back to the facility on 3/8/18. The facility failed to ensure that R20 received adequate supervision to prevent five resident to resident altercations that occurred between January 2018-March 2018. Findings were reviewed with E1 (NHA) and E2	F 689	three consecutive weeks or until 100% compliant. If audits are 100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QAPI monthly.	

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F 689	Continued From page 36 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R5) out of 49 sampled residents, the facility failed to ensure that R5 was provided respiratory care consistent with her physician orders and comprehensive person-centered care plan. Findings include: Review of R5's clinical record revealed the following: R5 was admitted to the facility on 2/25/15 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of R5's care plan revealed that starting on 2/28/15 and revised on 2/23/18, R5 had the potential for ineffective breathing patterns related to end stage COPD with oxygen dependence, R5 would also turn off her oxygen concentrator and remove her nasal cannula. Approaches included, to provide R5 with oxygen as ordered and to monitor R5's oxygen concentrator/tank closely.	F 695	1. R5 was not negatively impacted by this deficient practice. 2. All long term care residents receiving oxygen therapy (O2) have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Concentrators, not O2 tanks, will be used on all long term care residents on continuous O2. Residents who are on continuous O2 therapy and have a history of self removing O2 and/or demonstrate self removal of O2 will be given "Tender Grip" (O2 nasal cannula fixation system)to facility proper placement of nasal cannula. Staff educator to educate all licensed clinical staff on the facility Nasal O2 Administration Policy. All staff will be educated to notify nurse if residents with O2 are observed self removing O2 or are without nasal cannula.	9/1/18

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F 695	Continued From page 37 On 3/3/17, R5 had a physician's order for oxygen at 4L via nasal cannula check pulse oximetry every shift and may titrate oxygen to maintain pulse oximetry above 92%. During an observation on 5/16/18 at 1:35 PM, R5 was in her room hooked up to the oxygen concentrator via nasal cannula, however, the oxygen concentrator was turned down to 0L therefore R5 was not receiving any oxygen. During an interview on 5/17/18 at 1:22 PM, R5's representative stated that R5 needed oxygen and when visiting he had often found the oxygen tank empty and felt that staff do not check it. On 5/21/18 at 1:35 PM, R5 was observed sitting in the hall in a wheelchair in front of the nurse's station crying with her nasal cannula off and her portable oxygen tank was empty. Multiple staff members walked by for approximately 10 minutes and did not approach R5. The surveyor told E13 (LPN) that R5 needed assistance. E13 went over to address R5's crying and noticed her oxygen tank was empty. E13 replaced R5's oxygen tank and put her nasal cannula back on. At 1:52 PM, E13 was sitting at the nurse's station facing R5, when R5 pulled off her nasal cannula. Multiple staff members walked by for approximately 10 minutes and did not approach R5. At 2:02 PM, the surveyor told E13 that R5 did not have her nasal cannula on and E13 reapplied it. On 5/22/18 at 1:57 PM, R5 was observed sitting in a wheelchair by the nurse's station with her nasal cannula off. When the surveyor entered the unit, E13 got up from her chair at the nurse's station and put on R5's nasal cannula.	F 695	4. Staff educator to perform random observations to ensure that residents with O2 have proper placement of O2 and concentrator. Three random audits will be done daily or until 100% compliance is achieved for three consecutive days. Three random audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Three random audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random audit of three observations are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QAPI monthly.	

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F 695	Continued From page 38 During an observation on 5/24/18 at 9:20 AM, R5 was observed lying in bed with her nasal cannula off and oxygen turned on. The facility failed to provide R5 with her ordered respiratory care as evidenced by multiple observations of R5 without oxygen. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		9/1/18

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F 756	Continued From page 39 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for 5 (R20, R46, R68, R72, and R100) out of 49 sampled residents, the facility failed to have a consistent and accurate system in place where the facility's pharmacist identified and reported any irregularities during the monthly medication regimen reviews (MRRs) to the attending physician, the facility's medical director and the director of nursing. Individualized reports must be documented on a separate, written report that was sent to the physician, medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified so it may be acted upon. Additionally, the attending physician failed to consistently date and provide rationale for his/her decisions for identified irregularities by the pharmacist. Findings include: 1. Review of R100's clinical record revealed the following:	F 756	1. 1. R100 was not negatively impacted by this deficient practice. 2. All resident□s have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the correct action outlined below in #3. 3. DON/Designee will audit and reconcile all pharmacy recommendations received monthly to ensure that the provider includes the date that the requisition was signed and includes rationale if provider disagrees with recommendation. DON/Designee will personally follow up with provider to obtain clarification on all recommendations that do not have the required information. Corporate Informatics Nurse to modify MRR observation in Matrix to include N □ Nursing, P □ Provider, B □ Both (Nursing & Provider) or No Recommendation. Pharmacy Consultants to be educated by	

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F 756	Continued From page 40 8/17 - Review of the facility's Pharmacy MRR Observation Details form identified one irregularity which stated, "...P-alendronate/recent addition of omeprazole." 8/25/17 - Despite only one irregularity was captured on the facility's Pharmacy MRR Observation Details form, R100's clinical record revealed two (2) Notes to the Attending Physician/Prescriber from the facility's pharmacist and the prescriber's response: - "May we add diagnosis of epigastric pain or gerd for use of omeprazole added to therapy 8/21?" The facility's prescriber responded by agreeing and circling gerd and wrote "already in matrix". The facility's prescriber failed to date his/her response. - "Resident receives Alendronate...weekly. Order 8/21 added omeprazole for epigastric pain per nursing notes. Manufacturer of alendronate indicates increased risk of abdominal pain, gerd with alendronate and length of therapy recommendation of 3-5 years. Please evaluate current symptoms; assess duration of therapy/continued need. Also consider BMP/CBC to follow." The facility's prescriber response disagreed and stated, "keep meds as ordered". The facility's prescriber failed to date her/his response and failed to document her/his rationale in R100's medical record in response to the pharmacist's recommendation. 3/18 - Review of the facility's Pharmacy MRR Observation Details form lacked evidence of any identified pharmacy irregularity. 3/20/18 - Despite there was no irregularity identified on the March 2018 MRR, further review of R100's clinical record revealed the following	F 756	Pharmacy Director on the new process utilizing the updated Matrix MRR Observation. 4. Pharmacy Director/Designee will audit three random residents monthly MRR□s to ensure that date and rationale are listed on Physician MRR and that Matrix MRR documentation matches MRR report that the pharmacy generates daily x 3 days or until 100% compliance is met. Pharmacy Director/Designee will then audit 3 random residents three times weekly x 3 weeks or until 100% compliance is met. Pharmacy Director/Designee will then audit three random residents three times weekly x 3 weeks or until 100% compliance is met. If audit of three random residents in one month is 100% compliant the deficiency will be considered resolved. Results of investigations will be presented monthly at QAPI meeting. 2. 1. R68 was not negatively impacted by this deficient practice. 2. All resident□s have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the correct action outlined below in #3. 3. Corporate Informatics Nurse to modify MRR observation in Matrix to include N □ Nursing, P □ Provider, B □ Both (Nursing & Provider) or No Recommendation. Pharmacy Consultants to be educated by Pharmacy Director on the new process utilizing the updated Matrix MRR Observation.	

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F 756	Continued From page 41 pharmacy irregularity: - "This resident has an order for OxyIR 5mg prn which has not been used in more than 30 days. Please consider discontinuation of this order...". The facility's prescriber response agreed with the recommendation and signed/dated the form on 3/21/18. 5/18 - Review of the facility's Pharmacy MRR Observation Details form lacked evidence of any identified pharmacy irregularity. 5/1/18 - Despite there was no irregularity identified on the May 2018 MRR, further review of R100's clinical record revealed the following pharmacy irregularity: - "Resident receives Omeprazole 20mg Q AM since 08/2017 with dx of GERD. Manufacturer recommends reassessment of continued use after 4-8 weeks. Please evaluate continued need and consider dose reduction toward discontinuation if clinically appropriate...". The facility's prescriber response disagreed and signed/dated on 5/4/18. The facility's prescriber failed to document her/his rationale in R100's medical record in response to the pharmacist's recommendation. 5/29/18 at 10:06 AM - During an interview, E18 (facility's pharmacist) stated that the facility's pharmacist identifies irregularities by noting a "P-" for the physician on the facility's Pharmacy MRR Observation Details form. E18 was shown R100's March 2018 and May 2018 monthly review, which failed to identify that the pharmacist identified irregularities. E18 confirmed the finding. When asked why the pharmacist does not identify any nursing irregularities on the facility's Pharmacy MRR Observation Details form and instead are	F 756	4. Pharmacy Director/Designee will audit three random residents Matrix MRR documentation and compare to pharmacy generated MRR report to ensure that documentation matches daily x 3 days or until 100% compliance is met. Pharmacy Director/Designee will then audit 3 random residents three times weekly x 3 weeks or until 100% compliance is met. Pharmacy Director/Designee will then audit three random residents three times weekly x 3 weeks or until 100% compliance is met. If audit of three random residents in one month is 100% compliant the deficiency will be considered resolved. Results of investigations will be presented monthly at QAPI meeting. 3. 1. R46 was not negatively impacted by this deficient practice. 2. All resident□s have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the correct action outlined below in #3. 3. Corporate Informatics Nurse to modify MRR observation in Matrix to include N □ Nursing, P □ Provider, B □ Both (Nursing & Provider) or No Recommendation. Pharmacy Consultants to be educated by Pharmacy Director on the new process utilizing the updated Matrix MRR Observation. 4. Pharmacy Director/Designee will audit three random residents Matrix MRR documentation and compare to pharmacy generated MRR report to ensure that documentation matches daily x 3 days or	

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F 756	Continued From page 42 sending a comprehensive report listing all residents together every month with identified nursing recommendations separate to the facility's director of nursing to be acted upon, E18 stated that we have been doing it this way for the past 12 years and disagreed that nursing irregularities identified by the pharmacist during the MRR are included in the Federal Regulation. Despite the pharmacist identifying nursing irregularities during the MRR to be acted upon, the facility failed to identify them on the MRR and failed to include them as part of the residents' clinical records. 2. Review of R68's clinical record revealed the following: 2/2018 - Review of the facility's Pharmacy MRR Observation Details form lacked evidence of any identified pharmacy irregularity. 2/19/18 - Despite no irregularity identified on the February 2018 MRR, further review of R68's clinical record revealed the following pharmacy irregularities: "Resident's recent labs show Cholesterol. Would initiating statin therapy be appropriate at this time? "Resident receives Abilify 10 mg hs since 6/11/16. CMS guidelines require periodic dose reductions in order to determine lowest effective dose and reduce use of possible unnecessary medications. Please consider trial dose reduction to Abilify 5 mg hs at this time if appropriate." The facility's prescriber response agreed with the recommendations and signed/dated the form on 2/19/18.	F 756	until 100% compliance is met. Pharmacy Director/Designee will then audit 3 random residents three times weekly x 3 weeks or until 100% compliance is met. Pharmacy Director/Designee will then audit three random residents three times weekly x 3 weeks or until 100% compliance is met. If audit of three random residents in one month is 100% compliant the deficiency will be considered resolved. Results of investigations will be presented monthly at QAPI meeting. 4. 1. R20 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by t his deficient practice. Future residents will e protected by taking the correct action outlined below in #3. 3. Corporate informatics Nurse to modify MRR observation in Matrix to include N - Nursing, P- Provider, B - Both (Nursing & Provider) or No Recommendation. Pharmacy Consultants to be educated by Pharmacy Director on new process utilizing the updated Matrix MRR Observation. 4. Pharmacy Director/Designee will audit three random residents Matrix MRR documentation and compare to pharmacy generated MRR report to ensure that documentation matches daily x 3 days or until 100% compliance is met. Pharmacy Director/Designee will then audit 3 random residents three times weekly x 3 weeks or until 100% compliance is met. Pharmacy Director/Designee will then	

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F 756	Continued From page 43 3. Review of R46's clinical record revealed the following: 3/2018 - Review of the facility's Pharmacy MRR Observation Details form lacked evidence of any identified pharmacy irregularity. 3/22/18 - Despite no irregularity identified on the March 2018 MRR, further review of R46's clinical record revealed the following pharmacy irregularities: "The resident's hospital discharge on 3/15/18 shows Vistaril 50 mg q 6h, but the MAR shows this as a standing order TID." "The resident's hospital discharge notes on 3/15/18 shows Buspar 15 mg TID but the MAR shows this order as Buspar 20 mg TID." "The resident has Triamcinolone cream on her hospital discharge on 3/5/18. This order is not on her MAR." The facility's prescriber response stated 'order correct as written' was signed/dated on 3/22/18. 4. Review of R20's clinical record revealed the following: MRR's were completed by the consultant pharmacist for R20 from June 2017 through May 2018. Review of the facility's Pharmacy MRR Observation Details forms for June 2017 through May 2018 lacked evidence that the pharmacist ever documented whether there were or were not pharmacy irregularities during each monthly review. During each monthly review the pharmacist wrote notes and sometimes wrote irregularities under each month, but never documented in those notes to confirm that there was or was not a pharmacy recommendation.	F 756	audit three random residents three times weekly x 3 weeks or until 100% compliance is met. If audit of three random residents in one month is 100% compliant the deficiency will be considered resolved. Results of investigations will be presented monthly at QAPI meeting. 5. 1. R72 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by t his deficient practice. Future residents will e protected by taking the correct action outlined below in #3. 3. Corporate informatics Nurse to modify MRR observation in Matrix to include N - Nursing, P- Provider, B - Both (Nursing & Provider) or No Recommendation. Pharmacy Consultants to be educated by Pharmacy Director on new process utilizing the updated Matrix MRR Observation. 4. Pharmacy Director/Designee will audit three random residents Matrix MRR documentation and compare to pharmacy generated MRR report to ensure that documentation matches daily x 3 days or until 100% compliance is met. Pharmacy Director/Designee will then audit 3 random residents three times weekly x 3 weeks or until 100% compliance is met. Pharmacy Director/Designee will then audit three random residents three times weekly x 3 weeks or until 100% compliance is met. If audit of three random residents in one month is 100% compliant the deficiency will be considered resolved. Results of	

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F 756	Continued From page 44 The facility's Pharmacy MRR Observation Details form for R20 lacked evidence of any identified pharmacy irregularity for R20 for January 2018. Despite there was no irregularity identified on the January 2018 MRR, further review of R20's clinical record revealed the following pharmacy irregularity: 1/30/18: "May we add the following diagnosis to the POS? APAP 325mg DX: pain/fever." The facility's prescriber response agreed with the recommendation and signed/dated the form on 1/31/18. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM. 5. Review of R72's clinical record revealed the following: MRR's were completed by the consultant pharmacist for R72 from May 2017 through May 2018. Review of the facility's Pharmacy MRR Observation Details forms for May 2017 through May 2018 lacked evidence that the pharmacist ever documented whether there were or were not pharmacy irregularities during each monthly review. During each monthly review the pharmacist wrote notes and sometimes wrote irregularities under each month, but never documented in those notes to confirm that there was or was not a pharmacy recommendation. The facility's Pharmacy MRR Observation Details	F 756	investigations will be presented monthly at QAPI meeting.	

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F 756	Continued From page 45 form for R72 lacked evidence of any identified pharmacy irregularity for R72 for January 2018. Despite there was no irregularity identified on the January 2018 MRR, further review of R20's clinical record revealed the following pharmacy irregularity: 1/30/18: "May we add the following diagnosis to the POS? Miralax DX: Constipation, Pradin 1mg DX:DM." The facility's prescriber response agreed with the recommendation and signed/dated the form on 1/31/18. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		9/1/18

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F 757	Continued From page 46 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for 2 (R86 and R48) out of 49 sampled residents, the facility failed to ensure that each residents' drug regimen must be free from unnecessary drugs. For R86, the facility failed to ensure that physician-ordered parameters were followed for her blood pressure medication on 5/15/18. For R48, the facility failed to ensure that physician-ordered parameters were followed for her blood pressure medication on 1/30/18 and 3/16/18. Findings include: 1. Cross refer to F842. Review of R86's clinical record revealed the following: 4/27/18 - R86 was admitted to the facility with diagnoses that included high blood pressure. 5/2/18 - A physician's order stated to hold her blood pressure medication if her systolic blood pressure was less than 100 or heart rate below 60. 5/15/18 - R86's May 2018 eMAR revealed that her blood pressure was 105/58 and heart rate was 53. The eMAR revealed that the facility failed to follow the 5/2/18 physician-ordered parameters to hold her medication and R86 was administered the dose.	F 757	#1 1. R86 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. MD ordered parameters are attached to each medication as indicated on the MAR. Staff Educator to educate nurses regarding holding/administering medications as per MD order. Staff Educator/Pharmacy Consultant to perform three random medication observations monthly to ensure medication compliance. 4. DON/Designee will audit three random residents' cardiac medication administration history to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will conduct three random audits three times weekly or until 100% compliance is reached for three consecutive times. DON/Designee will then conduct three random audits one time a week for three consecutive weeks or until 100% compliant. If a random sample of three audits are 100% compliant in one month the deficiency will be considered resolved. Results of observations will be presented at QAPI	

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F 757	Continued From page 47 5/29/18 at 4 PM - During an interview, findings were reviewed with E2 (DON). The facility failed to ensure that physician-ordered parameters were followed for her blood pressure medication on 5/15/18. 5/30/18 at 6 PM - Findings were reviewed with E1 (NHA) and E2 during the Exit Conference. 2. Review of R48's clinical record revealed: 1/11/18- R48 had a physician's order placed for Lisinopril tablet 5 mg once a day, with special instructions to hold for a systolic blood pressure (SBP) less than 120. 1/31/18- Review of R48's January Medication Administration Record (MAR) revealed R48's blood pressure was 114/66 and Lisinopril was administered. 3/16/18- Review of R48's March Medication Administration Record (MAR) revealed R48's blood pressure was 113/57 and Lisinopril was administered. The facility failed to ensure that physician-ordered blood pressure parameters were followed for R48's blood pressure medication, as evidenced by, nursing staff administered Lisinopril to R48 on 1/30/18 and 3/16/18 when R48's SBP was below 120. 5/30/18 at 6 PM - Findings were reviewed with E1 and E2 during the Exit Conference.	F 757	monthly. #2 1. R48 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. MD ordered parameters are attached to each medication as indicated on the MAR. Staff Educator to educate nurses regarding holding/administering medications as per MD order. Staff Educator/Pharmacy Consultant to perform three random medication observations monthly to ensure medication compliance. 4. DON/Designee will audit three random residents' cardiac medication administration history to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will conduct three random audits three times weekly or until 100% compliance is reached for three consecutive times. DON/Designee will then conduct three random audits one time a week for three consecutive weeks or until 100% compliant. If a random sample of three audits are 100% compliant in one month the deficiency will be considered resolved. Results of observations will be presented at QAPI monthly.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		9/1/18

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F 758	Continued From page 48 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 49 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R100) out of 49 sampled residents, the facility failed to ensure that a resident would not receive psychotropic drugs pursuant to a PRN order unless that medication was necessary to treat a diagnosed specific condition that was documented in the clinical record. For R100, the facility failed to capture targeted symptoms/behaviors that R100 was experiencing prior to medicating her with an anti-anxiety medication, Ativan, on 4 occasions. Findings include: Review of R100's clinical record revealed the following: 7/16/13 - R100 was admitted to the facility and diagnoses included anxiety. 4/18 - According to R100's April 2018 eMAR, she was medicated with PRN Ativan on the following 4 occasions. The facility lacked evidence that R100 received the PRN Ativan for a specific condition that was documented in the clinical record for the following dates/times: - 4/26/18 at 12:36 AM; - 4/27/18 at 1:53 PM; - 4/27/18 at 10:26 PM; and - 4/30/18 at 12:52 PM.	F 758	1. R100 was not negatively impacted by this deficient practice. 2. All residents with PRN Psychotropic orders have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff Educator/Designee to in-service nursing staff regarding non-pharmacological approaches prior to administration of PRN psychotropic medications. In-servicing to be given regarding proper documentation of non-pharmacological interventions attempted. 4. DON/Designee will audit three random resident's PRN psychotropic medication administration histories to ensure compliance daily until 100% compliance is achieved for three consecutive days. DON/Designee will conduct three random audits three times weekly or until 100% compliance is reached for three consecutive times. DON/Designee will continue to conduct 3 random audits one time a week for three consecutive weeks or until 100% compliant. If a random audit of medication administration history are	

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F 758	Continued From page 50 4/29/18 at 3:30 PM - During an interview, findings were confirmed with E2 (DON). The facility failed to capture targeted symptoms/behaviors that R100 was experiencing prior to medicating her with a PRN anti-anxiety medication on 4 occasions. 4/30/18 at 6 PM - Findings were reviewed with E1 (NHA) and E2 during the Exit Conference.	F 758	100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QAPI monthly.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to properly store dry foods and monitor refrigerator temperatures daily in the resident dining room, to ensure food	F 812	1. No resident was negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future	9/1/18

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F 812	Continued From page 51 safety. Findings include: During a follow-up visit to the kitchen on 5/23/18 at 1:44 PM, an open bag of brown sugar was observed inside the brown sugar bin. In addition, a small piece of brown paper was observed inside the white sugar bin. These observations were confirmed with E6 (Director of Food Services) on 5/29/18 at 2:00 PM. On 05/29/18 at 7:45 AM, the reach-in refrigerator in the second floor dining room was observed to lack temperature measurements for 8 days, from 5/21/18 - 5/29/18. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/30/18 at 6:00 PM.	F 812	residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Dietary Compliance Assistant identified and given additional responsibilities to include temperature log management of all resident food refrigerators and that food storage compliance is maintained in the prep area of the kitchen where the sugar bins are located. 4. Dietician will audit sugar storage, sugar bins are free of debris and to ensure temperature logs daily or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If an audit of sugar storage, sugar bins, and temperate logs are 100% compliant in one month the deficiency will be considered resolved. Results of audit will be presented at QA Committee Meeting.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		9/1/18

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F 842	Continued From page 52 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842		

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F 842	Continued From page 53 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that for one (R86) out of 49 sampled residents, the facility failed to safeguard medical record information in accordance with accepted professional standards and practices. Findings include: Cross refer to F757, example 1. The facility's policy entitled Documentation Guidelines last revised on 5/15/17, stated, "It is the policy...to document accurately and timely in resident's medical records...Procedure: ...Entries into the medical record will be dated, timed and signed using full name and credentials...Late entry documentaion is entered with the current date and time and noted as a late entry...Late nursing entries to any part of the medical record are entered timely and noted as a late entry with the reason for entry specified within 72 hours...Incorrect entries are resolved electronically...the correction is entered as well as	F 842	1. No resident was negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff Educator will re-educate all nurses on facility policy and procedure that amending nursing documentation can not be done after 72 hours. 4. Staff educator to audit three random residents' late entry documentation daily or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random audit of three residents' late entry documentations are 100% compliant in	

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F 842	Continued From page 54 the reason for correction while retaining the legibility of the original entry...". Review of R86's clinical record revealed the following: 5/29/18 at 12:22 PM - R86's May 2018 eMAR was printed by the surveyor with a finding that the facility failed to follow physician-ordered parameters to hold a blood pressure medication on 5/15/18. 5/29/18 at 3:30 PM - During an interview, the finding was discussed with E2 (DON). 5/30/18 at approximately. 11:30 AM - During a follow-up interview, E 2 provided the surveyor with a printed copy of R 86' s' May 2018 eMAR, with a run date of 5/29/18 timed 6:16 PM. This eMAR revealed that R86's blood pressure medication was held on 5/15/18 by E19 (RN), who charted an additional note dated 5/15/18 and timed 9:35 AM that stated, "medication held due to parameters". 5/30/18 at 4:30 PM - During a combined interview with E2 and E4 (Corporate Nurse), the surveyor questioned E2 why R86's printed May 2018 eMAR on 5/29/18 at 6:16 PM was different from the printed eMAR on 5/29/18 at 12:22 PM by the surveyor. E4 stated that if a staff member documented any changes in the resident's eMAR after the original entry, the computer program would flag the change and capture the date and time of the revised entry. When asked by the surveyor if E19 (RN) worked yesterday (5/29/18), E2 stated yes, she worked on day shift. E2 excused herself from the interview briefly. E2 returned and stated that E20 (Staff Educator)	F 842	one month the deficiency will be considered resolved. Results of audit will be presented at QA Committee Meeting.	

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F 842	Continued From page 55 spoke with the nurse yesterday about R86's blood pressure medication/parameters and the nurse remembered that she held R86's medication on 5/15/18, a total of 15 days ago. R86's original entry on the May 2018 eMAR was altered by E19 (RN), 15 days later, to show that R86's blood pressure medication was held on 5/15/18 at 9:35 AM. 5/30/18 at 6 PM - Findings were reviewed with E1 (NHA) and E2 during the Exit Conference. The facility failed to safeguard medical record information in accordance with accepted professional standards and practices.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		9/1/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 56 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 57 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of CDC guidelines, it was determined that the facility failed to ensure that proper infection control techniques for hand washing were implemented during wound care for one (R97) out of 49 sampled residents. Findings include: An article titled "Recommendations from the CDC Guideline for Hand Hygiene in Healthcare Settings," (https://multimedia.3m.com/mws/media/309799O/cdc-guidelines-reprint.pdf) stated, "...Hand hygiene technique...B. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet...". During wound care of R97's left heel pressure ulcer on 5/24/18 at 10:32 AM, E5 (Wound Care Nurse) was observed washing her hands multiple times before R97's dressing change, in between the dressing change, and after the dressing change. The process during all of the hand washing observations took approximately 5 to 10 seconds. During the dressing change E5 was observed washing her hands after removing R97's old dressing. E5 placed her hands under the water and did not apply any soap, and then scrubbed her hands under the water for	F 880	1. R97 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff Educator to re-educate staff on Infection Control Policy and Procedures and proper hand washing technique. 4. Staff educator to perform infection control rounds daily for three days or until 100% compliance is achieved. Infection control rounds will then be done three times weekly or until 100% compliance is reached for three consecutive times. Infection control rounds will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three infection control rounds are 100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QA Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 58 approximately 5 seconds. After R97's dressing change was complete, E5 washed her hands again. E5 was observed wetting her hands, she then applied soap, and scrubbed her hands for approximately 10 seconds and rinsed off the soap. E5 then dried her hands with a paper towel and turned off the faucet with a bare hand. After finishing, E5 picked up a paper towel that was on the floor in R97's bathroom with her bare hand and placed it in the trash can. E5 failed to wash her hands after touching the contaminated paper towel. The facility failed to ensure that adequate hand hygiene was performed during R97's wound care according to professional standards of practice. Findings were reviewed and acknowledged by E5 on 5/24/18 at approximately 10:50 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:00 PM.	F 880		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Silverside **DATE SURVEY COMPLETED: May 30, 2018**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual/complaint survey was conducted at this facility from May 16, 2018 to May 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 114. The survey sample size was 49. **There were no deficiencies cited for the Emergency Preparedness survey.**		
3310	**Regulations for Skilled and Intermediate Care Facilities**		
3310.1.0	**Scope**		
3310.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross Refer to the CMS 2567-L survey completed May 30, 2018: F550, F583, F584, F600, F609, F636, F656, F658, F676, F684, F688, F689, F695, F756, F757, F758, F812, F842 and F880.	Cross refer to the plan of correction for CMS 2567-L survey completed May 30, 2018: F550, F583, F584, F600, F609, F636, F656, F658, F676, F684, F688, F689, F695, F756, F757, F758, F812, F842 and F880.	09/01/18

Provider's Signature [signature] Title NHA Date 6.26.18